Other Health Insurance Verification

Wells Fargo Insurance Services ■ P.O. Box 99004 ■ Anchorage, AK 99509-9004
Toll Free 877.517.6370 or TDD 877.517.6416 ■ Fax: 304.353.8636

Please complete this form annually to provide us with an update regarding any other health coverage you or your dependents may have. When you or your dependents have other health coverage, the information requested below will enable us to coordinate payment of your claim with your other carrier.

Member's Information

Name (First, Initial, Last)			Member ID	
Street Address / P. O. Box	**City**		**State**	**ZIP**
Employer			**Group Number**	
AlaskaCare			○ 5851 Active	○ 5852 Retired

Other Health Insurance Information

Does the member and / or dependent(s) have other health insurance coverage?

○ Yes ○ No (Select One) If yes, indicate the person(s) covered, effective date, and type of coverage below and return with a copy of the other insurance carrier's or Medicare's ID card.

Is the other insurance coverage Medicare?

○ Yes ○ No (Select One)

If yes, who is covered by Medicare? (If there is more than one member with Medicare please use a separate piece of paper.)

Name	Medicare ID (HIC #)	Part A Effective Date	Part B Effective Date	Part D Effective Date

Are you entitled to Medicare due to one of the following:	Date of Entitlement	Date of First Dialysis Treatment	Date of Kidney Transplant
○ Disability ○ End State Renal Disease			

Other Coverage For The Following Person(s) Name	Type of Benefits	Type of Coverage (Select One)	Effective Date of Other Coverage
	○ Medical ○ Dental ○ RX ○ Vision	○ Single ○ Family	
	○ Medical ○ Dental ○ RX ○ Vision	○ Single ○ Family	
	○ Medical ○ Dental ○ RX ○ Vision	○ Single ○ Family	
	○ Medical ○ Dental ○ RX ○ Vision	○ Single ○ Family	
	○ Medical ○ Dental ○ RX ○ Vision	○ Single ○ Family	

Dual Coverage Agreement for Dependents

To avoid duplication of payments your plan includes provisions to coordinate benefits which your dependents may have from another group plan. If an individual without custody of your children provides health, dental, vision or pharmacy coverage for your dependents these rules may apply:

1) If a court order decrees that an individual is financially responsible for child health care expenses, that plan must pay benefits first.
2) If no court order has directed the responsibility of the child's health care, the plan of the parent with custody must pay first.

Does the court order direct the responsibility of providing insurance benefits to an individual other than yourself?

○ Yes ○ No (Select One)

If yes, please provide:

Dependent's Name	Relationship	Date of Birth	Name of Person with Custody	Name of Person with Financial Responsibility According to Divorce Decree

Certification

By completing this Verification, I acknowledge that a person who knowingly makes a false statement, or falsifies or permits to be falsified, a record of the AlaskaCare Health Plan in an attempt to defraud the Plan, is guilty of a Class A misdemeanor, which, upon conviction, is punishable by a fine of not more than $500 or by imprisonment for not more than twelve months or both (AS 39.35.670; AS 11.56.210). I also acknowledge that a person who obtains funds and/or benefits by deception may be subject to prosecution for other crimes, including theft, which may be charged as misdemeanors or felonies with potential fines and penalties including funds and/or benefits from the System unlawfully may also be required to make restitution.

Member's Signature	**Date**